A Dr. Hallowell Protocol

SHINE *for* Doctors

Special Help Integrating Neurological Experience™

| | | |
|---|---|---|
| Name of Patient | Date | |
| Gender ☐ Male ☐ Female | Date of Birth / / | Age |
| Address | | |
| Address | Phone Number | |
| Parent(s) Name | | Age |
| Education Level Attained | | |
| Parent(s) Name | | Age |
| Education Level Attained | | |
| Legal Guardian | | |
| Person completing form | | |

**FAMILY HISTORY**

Family history can often be helpful in understanding a child's problems.

**Please check any box that applies:**

| ***Has anyone in the family had:*** | ***Siblings*** | ***Parents*** | ***Extended Family*** |
|---|---|---|---|
| Motor problems | | | |
| Reading problems | | | |
| Speech/language problems | | | |
| School/learning problems | | | |
| Alcohol/drug problems | | | |
| Anxiety, depression, other psychological disorders | | | |
| Seizures/epilepsy | | | |
| Attention problems/hyperactivity | | | |

Please list all family members (in or out of house) and other people currently in the house:

| NAME | RELATIONSHIP | AGE | CURRENTLY IN HOUSE? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐



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## BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, high blood pressure etc? _____

Did you receive any vaccinations while pregnant? ☐ Yes ☐ No

Was any dental work done while pregnant? ☐ Yes ☐ No If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of spouse's job, separation, etc?

_____

Please check what best describes your labour and birth of your child?

| | | |
|---|---|---|
| ☐ Normal (no interventions) | ☐ Rh Factor problems | ☐ Caesarian section |
| ☐ Mother was sick | ☐ Long/difficult labour | ☐ Forceps or suction used |
| ☐ Complications during birth | ☐ Epidural given | ☐ Induced |
| ☐ Problems with the umbilical cord | ☐ Facial/ breech/ brow presentation | |

Did your child have any of the following problems at birth:

| | | |
|---|---|---|
| ☐ Difficulty breathing | ☐ Heart problems | ☐ Infection |
| ☐ Low birth weight | ☐ Problems with bones/joints | ☐ Jaundice |
| ☐ Fever or seizures | ☐ Required blood transfusions | ☐ Intensive care |
| ☐ Bruised anywhere | ☐ Nerve Problems | |

Does this/ did this child have any birth defects? ☐ Yes ☐ No

If yes, list: _____

Describe what your child's temperament was like as an infant.

| | | | |
|---|---|---|---|
| ☐ Difficult | ☐ Calm | ☐ Sleepy | ☐ Hyper sensitive |
| ☐ Irritable | ☐ Active | ☐ Easily scared | ☐ Frequent crying |
| ☐ Sociable | ☐ Cranky | ☐ Happy | ☐ Alert |

During the first twelve months, was this child:

| | | | | | |
|---|---|---|---|---|---|
| Difficult to get to sleep | ☐ Yes | ☐ No | Irritable | ☐ Yes | ☐ No |
| Difficult to be put on a schedule | ☐ Yes | ☐ No | Alert | ☐ Yes | ☐ No |
| Easy to comfort | ☐ Yes | ☐ No | Affectionate | ☐ Yes | ☐ No |
| Overactive/in constant motion | ☐ Yes | ☐ No | Sociable | ☐ Yes | ☐ No |

Was the child breast fed? ☐ Yes ☐ No For how long? _____

When was solid food introduced? _____

Was there any evidence of food intolerances? ☐ Yes ☐ No

If so, to what? _____



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## DEVELOPMENTAL HISTORY:

| How old was the child when (s)he: | Average Age | Approximate Age | If not sure, please estimate | | |
|---|---|---|---|---|---|
| Sat | 4-7 mos | | Early | Average | Late |
| Walked | 12-17 mos | | Early | Average | Late |
| Toilet Trained | 18-36 mos | | Early | Average | Late |
| Said first words | 12-17 mos | | Early | Average | Late |
| Began using sentences | 36-60 mos | | Early | Average | Late |

## SPEECH AND LANGUAGE

Has his/her hearing ever been tested? ☐ Yes ☐ No
Does this child have a history of frequent ear infections? ☐ Yes ☐ No
Has (s)he ever had tubes placed in her/his ears? ☐ Yes ☐ No
Last hearing/audiology evaluation: PLACE _____ DATE: _____

Does this child have:
Any speech problems/difficulty speaking? ☐ Yes ☐ No
Have trouble understanding what is being said to him/her? ☐ Yes ☐ No
Has (s)he ever had a Speech and Language Evaluation? ☐ Yes ☐ No
If yes, where? _____ When? _____
RESULTS _____
Has (s)he ever had Speech/Language Therapy? ☐ Yes ☐ No
Is (s)he currently receiving Speech/Language Therapy? ☐ Yes ☐ No
If yes, where? _____ Frequency: _____

## MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? ☐ Yes ☐ No
Has (s)he ever had Occupational Therapy (OT) evaluation? ☐ Yes ☐ No
Is (s)he currently receiving OT services? ☐ Yes ☐ No
If yes, where?_____ Frequency: _____
Does (s)he have any gross motor problems (walking, running)? ☐ Yes ☐ No
Has (s)he ever had a Physical Therapy (PT) evaluation? ☐ Yes ☐ No
Is (s)he currently receiving PT services? ☐ Yes ☐ No
If yes, where?_____ Frequency: _____
Does this child use any adaptive devices (braces)? ☐ Yes ☐ No
If yes, please describe: _____


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## VISION

Has this child ever been to an eye doctor? ☐ Yes ☐ No

Most recent date: _____

Does this child wear glasses? ☐ Yes ☐ No

If yes, why? _____

Has this child ever been assessed for / diagnosed with:

☐ Binocular Vision ☐ Convergence Insufficiency

☐ Other Convergence Issues ☐ Fixation Issues

**IMPORTANT: if a child wears glasses, please bring them to the appointment**

## MEDICAL HISTORY

Is the child regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath

☐ Naturopath ☐ Dentist ☐ Other

Has the child had the following childhood or other diseases?

| | | | | |
|---|---|---|---|---|
| ☐ Bronchitis | ☐ Allergies | ☐ Abdominal Pains | ☐ Pertussis | ☐ Scarlet Fever |
| ☐ Bed Wetting | ☐ Asthma | ☐ Croup | ☐ Measles | ☐ Meningitis |
| ☐ Seizures | ☐ Chronic Colds | ☐ Colic | ☐ Mumps | ☐ Rubella |
| ☐ Chicken Pox | ☐ Ear Infections | | | |

Does this child have/had braces on his/her teeth? ☐ Yes ☐ No

Does this child have any amalgam fillings? How many? ☐ Yes ☐ No

How many continuous hours is the child sleeping? _____

Is she/he well rested in the morning? ☐ Yes ☐ No

Does the child suffer from sleep difficulties? ☐ Yes ☐ No

Does the child have problems with food/eating? ☐ Yes ☐ No

Is the child a fussy eater? ☐ Yes ☐ No

Does the child have issues with hygiene/cleanliness? ☐ Yes ☐ No

Does the child complain of any ongoing physical pains? (headaches, tummy aches, muscle/joint aches, or growing pains) ☐ Yes ☐ No

Does the child suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? ☐ Yes ☐ No

Has this child received any vaccines? ☐ Yes ☐ No

If yes, please list: _____

Were there any of the following adverse reactions noticed? ☐ Yes ☐ No

☐ Inconsolable crying ☐ High fever ☐ Sleep disruptions afterward

☐ Lethargy ☐ Irritability ☐ Developed allergies

How many courses of antibiotics has this child received? _____



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Has this child taken any other prescription medication in the past? ☐ Yes ☐ No

If yes, what were/are they? _____

_____

Is the child exposed to a toxic environment (including passive smoking)? ☐ Yes ☐ No

Has the child had any serious falls, physical traumas, or physical injuries? ☐ Yes ☐ No

Please list: _____

_____

_____

_____

_____

## SCHOOL HISTORY

Does the child like/enjoy school? ☐ Yes ☐ No

If not, why not? _____

_____

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| English | S ☐ | W ☐ | Math | S ☐ | W ☐ | Music | S ☐ | W ☐ |
| History | S ☐ | W ☐ | Science | S ☐ | W ☐ | Creative Writing | S ☐ | W ☐ |
| Gym/Sports | S ☐ | W ☐ | Other languages | S ☐ | W ☐ | Other: | S ☐ | W ☐ |
| Art | S ☐ | W ☐ | | | | | | |

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Concentration | S ☐ | W ☐ | Organization | S ☐ | W ☐ | Test Preparation | S ☐ | W ☐ |
| Handwriting | S ☐ | W ☐ | Planning | S ☐ | W ☐ | "Good" behaviour | S ☐ | W ☐ |
| Memorizing | S ☐ | W ☐ | Reading quickly | S ☐ | W ☐ | Vocabulary and Expression | S ☐ | W ☐ |
| Paying attention | S ☐ | W ☐ | Spelling | S ☐ | W ☐ | Creative Writing | S ☐ | W ☐ |
| Reading comprehension | S ☐ | W ☐ | Getting assignments done on time | S ☐ | W ☐ | Understanding concepts | S ☐ | W ☐ |

Is getting homework done a struggle? ☐ Yes ☐ No

## BEHAVIOUR/MENTAL HEALTH

Describe any sports or activities the child is involved in: _____

_____

_____

Indicate how many hours a week of "screen time" the child uses:

Computer _____ Smart Device (phone, iPad, etc.) _____

Computer games (DS, etc.) _____ Television _____



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Describe the child's family relationships; with parents and siblings:

_____

_____

Does your child have many friends? ☐ Yes ☐ No

Does the child appear to excel at or struggle to build relationships with their peers? ☐ Excel ☐ Struggle ☐ Neither

If they struggle, why do you think that is?

_____

_____

What problems does the child have with peers, if any?

☐ None ☐ Bragging to peers ☐ Being Teased
☐ Being physically attacked ☐ Rejected by peers ☐ Overly physically affectionate
☐ Being bullied ☐ Jealous of peers

Does this child have self-esteem issues? ☐ Yes ☐ No

Which of the following has the child experienced in the last 12 months?

☐ None ☐ Mother pregnant ☐ Parents separation/divorce
☐ Change of school ☐ Birth of a sibling ☐ Move to a new home
☐ Parent losing a job ☐ Death of immediate family member ☐ Serious illness/injury in immediate family
☐ Other: _____

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age? (Please put a check in front of any that apply)

☐ Often touchy/easily annoyed ☐ Often bullies/threatens ☐ Often irritable
☐ Often defies adult rules ☐ Initiates physical fights ☐ Changes in appetite
☐ Often angry/resentful ☐ Ever been arrested ☐ Diminished interest
☐ Often argues with adults ☐ Physically cruel to others ☐ Sleep problems
☐ Often loses temper ☐ Physically cruel to animals ☐ Restlessness or slowed down
☐ Blames other for mistakes ☐ Motor or vocal tics ☐ Fatigues/low energy
☐ Deliberately annoys ☐ Destroys property ☐ Feels worthless
☐ Often spiteful/vindictive ☐ Deliberately sets fires ☐ Becomes tearful easily
☐ Refuses to go to school ☐ Lies often ☐ Often sad
☐ Repeated nightmares ☐ Steals ☐ Indecisive/can't think
☐ Unusual fears ☐ Has run away ☐ Thinks about death
☐ Panic attacks ☐ Extreme mood swings ☐ Talks about suicide
☐ Self-conscious/clings ☐ Does not show emotions ☐ Hurts self
☐ Excessive need for reassurance ☐ Overreacts to touch/noise ☐ Currently uses drugs
☐ Self-injurious behaviour ☐ Strange or bizarre ideas ☐ Currently drinks beer or alcohol
☐ Worry of future events ☐ Used drugs in the past ☐ Used beer or alcohol in the past
☐ Repeats certain actions ☐ Poor social interactions ☐ Can't stop thinking about things
☐ Somatic complaints (headache/stomach) ☐ Gets upset by changes in routine ☐ Excessive preoccupation with objects or ideas
☐ Difficulty maintaining friendships



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| Please place a check mark in the column which best describes the child: | Not at all | Just a little | Pretty much | Very much |
|---|---|---|---|---|
| Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities. | | | | |
| Often has difficulty sustaining attention in tasks or play activities. | | | | |
| Often does not seem to listen when spoken to directly. | | | | |
| Often does not follow through on instructions and fails to finish schoolwork, or chores (not due to oppositional behavioural failure to understand directions). | | | | |
| Often has difficulty organizing tasks and activities. | | | | |
| Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) | | | | |
| Often loses things necessary for tasks or activities (toys, school assignments, pencils or books) | | | | |
| Is often easily distracted by extraneous stimuli | | | | |
| Is often forgetful in daily activities | | | | |
| Often fidgets with hands or feet or squirms in seat | | | | |
| Often leaves seat in classroom or in other situation in which remaining seated is expected | | | | |
| Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness) | | | | |
| Often has difficulty playing or engaging in leisure activities quietly | | | | |
| Is often "on the go" or often acts as if "driven by a motor" | | | | |
| Often talks excessively | | | | |
| Often blurts out answers before questions have been completed | | | | |
| Often has difficulty waiting turn | | | | |
| Often interrupts or intrudes on others (butts into conversations or games) | | | | |



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**REASON FOR ASSESSMENT**

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

Your name _____ Relationship to child _____

Date:___/_____/_____



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